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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/19/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
3 phase bone scan to rule out dysautonomia versus infection

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgery

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines
Request for IRO dated 01/03/12
Utilization review determination dated 12/09/11
Utilization review determination dated 12/22/11
Clinical records Dr. dated 03/30/11-12/14/11
Operative report dated 05/17/11
MRI left shoulder dated 04/14/11
Operative report dated 06/20/09
Radiographic report shoulder dated 05/17/11
Lab reports 05/13/11

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a male who is reported to have sustained an injury to his left shoulder on xx/xx/xx. No mechanism of injury is described. The claimant is noted to have undergone rotator cuff repair on 06/20/09. It is noted at this time the claimant had massive rotator cuff tear with retraction. He underwent open subacromial decompression with excision of CA ligament of shoulder. Because of massiveness of tear it was not repaired. The claimant subsequently received chiropractic care from Dr. D.C. and later referred to Dr. on 03/30/11. On physical examination he has healed surgical wound at anterolateral aspect of left shoulder with long axis of arm. There is severe pain in this area with decreased range of motion. There is supra and infraspinatus muscle atrophy. Radiographs revealed superior migration of humeral head. He is to be referred for MRI to assess status of subscapularis tendon. It was opined he would most likely need shoulder replacement. Records indicate on 04/14/11 he underwent MRI of left shoulder, which showed postsurgical changes from acromioplasty. There was upward displacement of humeral head with narrowing of acromion humeral distance and large full thickness rotator cuff tear with retraction and gap measuring

4.28 cm in diameter. The retracted tendon is noted at level of AC joint. There is marked atrophy of supraspinatus muscle. The long head of biceps is in normal position. Fluid is seen within subacromial subdeltoid bursa. There is marked AC joint arthropathy with mild medial outlet narrowing. Records indicate the claimant was subsequently taken to surgery on 05/17/11 at which time Dr. performed left shoulder hemiarthroplasty with cuff tear, arthropathy, head pectoralis major transfer, rotator cuff repair, biceps tenodesis. Postoperatively he was seen in follow-up on 05/25/11 and reported no fevers or chills. He does not want Hydrocodone because it makes him dizzy. On physical examination he has clean surgical wounds. There are no new neurologic deficits. Prosthesis is reported to be in perfect position without signs of loosening. He is to be seen in one week for removal of stitches. The claimant returned on 06/01/11.

He reported he has not tolerated Motrin. He reported it causes him to go bathroom very often. On physical examination he has clean surgical wounds. Sutures were removed without complications. He is to follow-up in one month at which point he will restart physical rehabilitation with Dr. D.C. The claimant was seen in follow-up on 07/18/11. He has complaints of pain in the left shoulder in spite of physical medicine rehabilitation. He has been doing home stretching exercises. He was reported to be doing his exercises incorrectly and informed to stop doing stretching before point of pain. Physical examination indicates atrophy of deltoid. There is passive forward flexion of 100 degrees. Active forward flexion is 30. Radiographs performed at this visit were unremarkable. He was educated on home stretching exercises. The claimant was seen in follow-up on 08/22/11 and continues to have problems with left shoulder despite physical therapy. He reported he cannot sleep at night when he leans on his left side. Physical examination indicates severe tenderness to palpation along acromioclavicular joint exacerbated by palpation and overhead adduction. There is forward flexion of 100 degrees. External rotation is to 0 degrees. Internal rotation is to posterior head. He is recommended to undergo acromioclavicular joint injection. The claimant was seen in follow-up on 11/30/11. He is reported to be scheduled to start pain management program. On physical examination he has limited range of motion, no signs of infection, no pain to passive range of motion. Motion is limited due to pain in forward flexion plane. He is recommended to undergo three phase bone scan to rule out dysautonomia versus infection. The claimant was seen in follow-up on 12/14/11. It is noted his bone scan was denied. He reported symptoms are unchanged. Physical examination is unchanged. He notes not all patients have negative bone scan to rule out dysautonomia. He reported the reason for ordering bone scan is to have better picture of possibility the patient may have infection on left shoulder. Three phase bone scan is recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The records indicate this claimant is status post a left shoulder hemiarthroplasty on 05/17/11. Serial postoperative notes provide no indication the claimant has any evidence of infection. Radiographs showed no evidence of hardware failure. There is no evidence of sympathetic dysfunction on examination. There is indication the claimant underwent lesser evaluations for infection. It would appear from Dr. note dated 12/14/11 that his primary concern is that of infection to left shoulder. There is no indication of lab studies being performed. As such, the reviewer finds there is insufficient clinical data to establish medical necessity for performance of 3 phase bone scan to rule out dysautonomia versus infection. The reviewer finds medical necessity does not exist for 3 phase bone scan to rule out dysautonomia versus infection. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)